	FO	FOR BHF USE			

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### 2005 STATE OF ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE

OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 00	19489		II. CERTIF	FICATION BY AUTHORIZED FACILITY OFFICER
	Facility Name: Manorcare at Westmont				
	Address: 512 East Ogden Avenue	Westmont	60559	State of	e examined the contents of the accompanying report to the Illinois, for the period from 06/01/04 to 05/31/05
	Number	City	Zip Code		ify to the best of my knowledge and belief that the said contents accurate and complete statements in accordance with
	County: DuPage			applicab	ole instructions. Declaration of preparer (other than provider)
	Telephone Number: (630)323-4400	Fax # (630)323-4583		is based	d on all information of which preparer has any knowledge.
	HFS ID Number: 520970446001				tional misrepresentation or falsification of any information ost report may be punishable by fine and/or imprisonment.
	Date of Initial License for Current Owners:	05/01/77			(Signed)
	Type of Ownership:			Officer or Administrator	(Type or Print Name) Barry A. Lazarus
	Type of Ownership.			of Provider	(Type of Trint Name) Daily A. Lazarus
	VOLUNTARY,NON-PROFIT	X PROPRIETARY	GOVERNMENTAL		(Title) Vice President, Reimbursement
	Charitable Corp.	Individual	State		
	Trust	Partnership	County		(Signed)
	IRS Exemption Code	X Corporation	Other		(Date)
		"Sub-S" Corp.			(Print Name
		Limited Liability Co	0.	Preparer	and Title)
		Trust Other			(Firm Name
		Other			& Address)
					(Telephone) ( ) Fax # ( ) MAIL TO: BUREAU OF HEALTH FINANCE
	In the event there are further questions about				ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
	Name: Gary Geise	Telephone Number: (419)2	252-5731		201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

STATE OF ILLINOIS Page 2

Facility Name & ID Number	er Manorcare a	t Westmont				# 0019489 Report Period Beginning: 06/01/04 Ending: 05/31/05
III. STATISTICAL	L DATA					D. How many bed-hold days during this year were paid by the Department?
A. Licensure/co	ertification level(s) of	f care; enter number	of beds/bed days,			(Do not include bed-hold days in Section B.)
(must agree v	with license). Date of	change in licensed b	oeds		_	
					<del>_</del>	E. List all services provided by your facility for non-patients.
1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)
						None
Beds at				Licensed		
Beginning of	Licensu	re	Beds at End of	<b>Bed Days During</b>		F. Does the facility maintain a daily midnight census? Yes
Report Period	Level of	Care	Report Period	Report Period		
						G. Do pages 3 & 4 include expenses for services or
1 155	Skilled (SNI		155	56,575	1	investments not directly related to patient care?
2		atric (SNF/PED)			2	YES NO X
3	Intermediat	- ( - /			3	
4	Intermediat				4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5	Sheltered C	. ,			5	YES NO X
6	ICF/DD 16	or Less			6	I. On what date did you start providing long term care at this location?
7 155	TOTALS		155	56,575	7	Date started 05/01/77
1 133	TOTALS		133	30,373	,	Date started 05/01/7
						J. Was the facility purchased or leased after January 1, 1978?
B. Census-For	the entire report per	iod.				YES Date NO X
1	2	3	4	5		
Level of Care	Patient Days	by Level of Care an	d Primary Source of	Payment		K. Was the facility certified for Medicare during the reporting year?
	Medicaid	-y			1	YES X NO If YES, enter number
	Recipient	Private Pay	Other	Total		of beds certified 155 and days of care provided 19,597
8 SNF	14,510	12,929	23,450	50,889	8	
9 SNF/PED					9	Medicare Intermediary Highmark Medicare Services
10 ICF					10	
11 ICF/DD					11	IV. ACCOUNTING BASIS
12 SC					12	MODIFIED
13 DD 16 OR LESS					13	ACCRUAL X CASH* CASH*
14 TOTALS	14,510	12,929	23,450	50,889	14	Is your fiscal year identical to your tax year? YES NO X
	cupancy. (Column 5, a line 7, column 4.)	line 14 divided by to 89.95%	otal licensed			Tax Year: 12/31/05 Fiscal Year: 05/31/05 * All facilities other than governmental must report on the accrual basis.

STATE OF I	LLI	NOIS				Page 3
	#	0019489	Report Period Reginning	06/01/04	Ending:	05/31/05

		Manorcare at V			#	0019489	Report Period	Beginning:	06/01/04	Ending:	05/31/05	_
	V. COST CENTER EXPENSES (through				llar)						T105 011 11	
			Costs Per Genera			Reclass-	Reclassified	Adjust-	Adjusted	FOR OHE	USE ONLY	
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	349,286	26,044	1,926	377,256	3,433	380,689		380,689	<u> </u>		1
2	Food Purchase		229,327		229,327		229,327	(429)	228,898			2
3	Housekeeping	182,525	28,708	3,539	214,772		214,772		214,772	<u> </u>		3
4	Laundry	58,345	22,207	7,336	87,888		87,888		87,888	<u>                                       </u>		4
5	Heat and Other Utilities			177,997	177,997	7,919	185,916		185,916			5
6	Maintenance	43,729	30,628	69,567	143,924		143,924		143,924			6
7	Other (specify):* Medical Waste			3,652	3,652		3,652		3,652			7
8	TOTAL General Services	633,885	336,914	264,017	1,234,816	11,352	1,246,168	(429)	1,245,739	<u> </u>		8
	B. Health Care and Programs											
9	Medical Director			33,030	33,030		33,030		33,030	<u>                                       </u>		9
10	Nursing and Medical Records	3,503,984	258,720	34,994	3,797,698	58,548	3,856,246		3,856,246			10
10a	Therapy	505,272	11,443	530,146	1,046,861		1,046,861		1,046,861			10a
11	Activities	102,480	5,512	2,075	110,067		110,067		110,067			11
12	Social Services	60,208		400	60,608		60,608		60,608			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,171,944	275,675	600,645	5,048,264	58,548	5,106,812		5,106,812	l	1	16
	C. General Administration											
17	Administrative	78,433		459,726	538,159	(147,138)	391,021		391,021			17
18	Directors Fees											18
19	Professional Services			17,741	17,741		17,741	(17,741)				19
20	Dues, Fees, Subscriptions & Promotions			107,832	107,832		107,832	(52,729)	55,103			20
21	Clerical & General Office Expenses	434,233	51,751	172,601	658,585		658,585	(115,962)	542,623			21
22	Employee Benefits & Payroll Taxes			839,048	839,048	53,826	892,874		892,874			22
23	Inservice Training & Education			2,189	2,189	·	2,189		2,189			23
24	Travel and Seminar			3,328	3,328		3,328		3,328			24
25	Other Admin. Staff Transportation			,	· ·				<i>'</i>			25
26	Insurance-Prop.Liab.Malpractice			173,856	173,856		173,856		173,856			26
27	Other (specify):* Purch. Serv. Admin.			190	190		190	(190)	*			27
28	TOTAL General Administration	512,666	51,751	1,776,511	2,340,928	(93,312)	2,247,616	(186,622)	2,060,994			28
20	TOTAL Operating Expense	5 219 405	664 240	2 641 172	9 624 009	(22,412)	9 600 506	(197.051)	9 412 545			20
29	(sum of lines 8, 16 & 28)	5,318,495	664,340	2,641,173	8,624,008	(23,412)	8,600,596	(187,051)	8,413,545	<b></b>	<u> </u>	29

\*\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

# V. COST CENTER EXPENSES (continued)

**Facility Name & ID Number** 

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			507,640	507,640	23,412	531,052		531,052			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			108,606	108,606		108,606		108,606			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			100,370	100,370		100,370		100,370			35
36	Other (specify):* Gain/Loss on Asset	S		1,487	1,487		1,487	(1,487)				36
37	TOTAL Ownership			718,103	718,103	23,412	741,515	(1,487)	740,028			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,157	1,157		1,157		1,157			38
39	Ancillary Service Centers		594,145		594,145		594,145		594,145			39
40	Barber and Beauty Shops		430	19,512	19,942		19,942		19,942			40
41	Coffee and Gift Shops	15,371			15,371		15,371		15,371			41
42	Provider Participation Fee			84,864	84,864		84,864		84,864			42
43	Other (specify):* IV   X-Ray & Lab		151,039	91,846	242,885		242,885		242,885			43
44	TOTAL Special Cost Centers	15,371	745,614	197,379	958,364		958,364		958,364	•		44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,333,866	1,409,954	3,556,655	10,300,475		10,300,475	(188,538)	10,111,937			45

<sup>\*</sup>Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Manorcare at Westmont

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Westmont

# 0019489 **Report Period Beginning:**  06/01/04

**Ending:** 

Page 5 05/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 2 Below	Amount	2 Refer- ence	OHF USE ONLY	lai Cos
1	Day Care	\$		10	\$	1
2	Other Care for Outpatients					2
3	Governmental Sponsored Special Programs					3
4	Non-Patient Meals		(429)	2		4
5	Telephone, TV & Radio in Resident Rooms		(9,217)	21		5
6	Rented Facility Space					6
7	Sale of Supplies to Non-Patients					7
8	Laundry for Non-Patients					8
9	Non-Straightline Depreciation			30		9
10	Interest and Other Investment Income			32		10
11	Discounts, Allowances, Rebates & Refunds			21		11
12	Non-Working Officer's or Owner's Salary					12
13	Sales Tax		(295)	21		13
14	Non-Care Related Interest					14
15	Non-Care Related Owner's Transactions					15
16	Personal Expenses (Including Transportation)		(190)	27		16
17	Non-Care Related Fees					17
18	Fines and Penalties		(180)	21		18
19	Entertainment					19
20	Contributions			21		20
21	Owner or Key-Man Insurance					21
22	Special Legal Fees & Legal Retainers		(17,741)	19		22
23	Malpractice Insurance for Individuals					23
24	Bad Debt		(102,743)	21		24
25	Fund Raising, Advertising and Promotional		(52,729)	20		25
	Income Taxes and Illinois Personal					
	Property Replacement Tax					26
27	CNA Training for Non-Employees					27
28	Yellow Page Advertising		/ <del>5</del> 01 4			28
29	Other-Attach Schedule		(5,014)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$	(188,538)		\$	30

	OHF USE ONL	Y				
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1	_	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (188,538	)	37

<sup>\*</sup>These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.) 1 2

4 3

		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
	Gift and Coffee Shops		X			40
	Barber and Beauty Shops		X			41
	Laboratory and Radiology		X			42
	Prescription Drugs		X			43
	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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Manorcare at Westmont

I	D#0019489
Report Period Beginning:	06/01/04
Ending:	05/31/05

Sch. V Line

	NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$	(1,791)	21	1
2	Misc. Income	Ψ	(1,736)	21	2
3	Loss of Disposal of Fixed Asset		(1,487)	36	3
4	Loss of Disposal of Fixed Asset		(1,467)	30	4
					_
5					5
7					7
9					9
					_
10					10
11					11
12					12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
22					22
23					23
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25					25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
35					35
36					36
37					37
38		+			38
39					39
40					40
41					41
42					41
43		+			42
44					43
					_
45					45
46					46
47					47
48					48
49	Total		(5,014)		49

STATE OF ILLINOIS

Summary A Facility Name & ID Number Manorcare at Westmont 05/31/05 # 0019489 Report Period Beginning: 06/01/04 **Ending:** 

	SUMMARY OF PAGES 5, 5A, 6, 6A	A, 6B, 6C, 6D, 6	E, 6F, 6G, 6H	I AND 6I									
													SUMMARY
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	<b>6F</b>	6G	6H	<b>6I</b>	(to Sch V, col.7)
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0 1
2	Food Purchase	(429)	0	0	0	0	0	0	0	0	0	0	(429) 2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0 3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0 4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0 5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0 6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 7
8	TOTAL General Services	(429)	0	0	0	0	0	0	0	0	0	0	(429) 8
	B. Health Care and Programs												
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0 9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0 10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0 10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0 11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0 12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0 13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0 14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0 16
	C. General Administration												
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0 17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0 18
19	Professional Services	(17,741)	0	0	0	0	0	0	0	0	0	0	(17,741) 19
20	Fees, Subscriptions & Promotions	(52,729)	0	0	0	0	0	0	0	0	0	0	(52,729) 20
21	Clerical & General Office Expenses	(115,962)	0	0	0	0	0	0	0	0	0	0	(115,962) 21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0 22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0 23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0 24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0 25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0 26
27	Other (specify):*	(190)	0	0	0	0	0	0	0	0	0	0	(190) 27
28	TOTAL General Administration	(186,622)	0	0	0	0	0	0	0	0	0	0	(186,622) 28
	TOTAL Operating Expense					· · · · · ·		<del> </del>					
29	(sum of lines 8,16 & 28)	(187,051)	0	0	0	0	0	0	0	0	0	0	(187,051) 29

STATE OF ILLINOIS
Facility Name & ID Number Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/04 Ending: 05/31/05

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	<b>6E</b>	<b>6F</b>	6 <b>G</b>	6H	<b>6I</b>	(to Sch V, col	.7)
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(1,487)	0	0	0	0	0	0	0	0	0	0	(1,487)	36
37	TOTAL Ownership	(1,487)	0	0	0	0	0	0	0	0	0	0	(1,487)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST						·							
45	(sum of lines 29, 37 & 44)	(188,538)	0	0	0	0	0	0	0	0	0	0	(188,538)	45

# Facility Name & ID Number VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

A. Litter below the names of ALL	owners and re	ateu organizations (parties) as denned in ti	ie ilistructions. Attach a	i additional schedule il necessary.			
1		2		3			
OWNERS		RELATED NURSING HOM	OTHER REL	ATED BUSINESS ENTITI	ES		
Name	Ownership %	Name	City	Name	City	Type of Business	
Manor Care, Inc.	100	Health Care & Retirement Corporation					
		of America (See H.O. Cost Report)					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

Manorcare at Westmont

_	4		for determining costs as specified i	4				0.70100	
	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
			20011	12	Think of House Organization	Ownership		Costs (7 minus 4)	
L									
1	V	See	Home Office Allocation	<b>\$</b> 459,726	HCR Manor Care, Inc.	100.00%	\$ 459,726	\$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management	41,068	Heartland Management Services	100.00%	41,068		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 500,794			\$ 500,794	\$ *	14

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/04 Ending: 05/31/05

## VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5		6	7	1	8	
						Average Hou	ırs Per Work				
					Compensation		oted to this	Compensati	on Included	Schedule V.	
					Received	Facility and	l % of Total	in Costs		Line &	
				Ownership	From Other	Work	Week	Reportin	ng Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10					·						10
11											11
12											12
13								TOTAL	\$		13

<sup>\*</sup> If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

<sup>\*\*</sup> This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).

FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.

ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

STATE OF ILLINOIS Page 8

# 0019489 Report Period Beginning: Facility Name & ID Number Manorcare at Westmont 06/01/04 Ending: 05/31/05

### VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	HCR Manor Care, Inc.
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	333 North Summit St.
or parent organization costs? (See instructions.)	City / State / Zip Code	Toledo, OH 43604-2617
<del>_</del>	Phone Number	(419) 252-5500
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	( 419 ) 254-5495

			2,2						<del></del>	
	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	<b>Total Indirect</b>	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	<b>Total Units</b>	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	\$	\$		\$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	1,043,233	571,891	9,309,004	3,433	2
3	5	Utilities - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	223,707		9,309,004	881	3
4	5	Utilities - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	2,139,042		9,309,004	7,038	4
5	10	Nursing - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	12,987,607	8,226,246	9,309,004	51,137	5
6	10	Nursing - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	2,252,260	1,199,059	9,309,004	7,411	6
7	17	General & Admin - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	16,611,639	15,056,893	9,309,004	65,406	7
8	17	General & Admin - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	75,121,310	43,509,256	9,309,004	247,182	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	3,924,545		9,309,004	15,452	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	11,662,215		9,309,004	38,374	10
11	30	Depreciation - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	0		9,309,004	0	11
12	30	Depreciation - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	7,114,804		9,309,004	23,412	12
13										13
14	32	Interest				10,002,527			0	14
15										15
16										10
17										17
18										18
19										19
20										20
21						<u> </u>				21
22										22
23										23
24										24
25	TOTALS					\$ 143,082,889	\$ 68,563,345		\$ 459,726	25

Facility Name & ID Number	Manorcare at Westmor	nt		STATE OF 1	ILLINOIS Report Period Beg	inning:	06/01/04	Ending:	Page 9 05/31/05
IX. INTEREST EXPENSE A A. Interest: (Complete det	· ·		parate schedule if	f necessarv.)				J	
ì	2	3	4	5	6	7	8	9	10

Reporting Period Interest Expense
Interest
Expense
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15

16)	Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.	\$ N/A	Line #	

<sup>\*</sup> Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

<sup>\*\*</sup> If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS Page 10
# 0019489 Report Period Beginning: 06/01/04 Ending: 05/31/05

Facility Name & ID Number Manorcare at Westmont

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

B. Real Estate Taxes						
	<b>Important</b> , please see the next workshe	et, "RE Tax". The real	estate tax statement and			
1. Real Estate Tax accrual used on 2004 report.	bill must accompany the cost report.	· =		\$	76,242	1
2. Real Estate Taxes paid during the year: (Indicate the t	tax year to which this payment applies. If payment c	overs more than one year, de	tail below.)	\$	91,611	2
3. Under or (over) accrual (line 2 minus line 1).				\$	15,369	3
4. Real Estate Tax accrual used for 2005 report. (Detail	and explain your calculation of this accrual on the	ines below.)		\$	93,237	4
5. Direct costs of an appeal of tax assessments which ha  (Describe appeal cost below. Attach copie)	•			\$		5
6. Subtract a refund of real estate taxes. You must offse classified as a real estate tax cost plus one-half of any TOTAL REFUND \$ For	remaining refund.	real estate tax appeal	board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line	e 33. This should be a combination of lines 3 thru 6.			\$	108,606	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year: 2000	80,739 8		FOR OHF USE ONLY			
2001 2002	81,916 9 86,644 10	13	FROM R. E. TAX STATEMENT FO	OR 2004 \$		13
2003 2004	82,423 11 100,797 12	14	PLUS APPEAL COST FROM LINE	£5 <b>\$</b>		14
Line 2: \$91,611 = \$50,399 for 1st half of 2004 + \$41,212 for						
Line 4: $$93,237 = $42,839$ for Jan-May $2005 + $50,398$ for	or 2nd half of 2004	15	LESS REFUND FROM LINE 6	\$		15

NOTES:

- 1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

### IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

### 2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FAC	ILITY NAME Manorcare at	Westmont	COUNTY	DuPage
FAC	ILITY IDPH LICENSE NUMBE	R 0019489		
CON	TACT PERSON REGARDING	ΓΗΙS REPORT Gary Geise		
TEL	EPHONE (419) 252-5731	FAX	#: (419) 254-5495	
A.	Summary of Real Estate Tax (	Cost		
	cost that applies to the operation home property which is vacant, i	real estate tax assessed for 2004 on of the nursing home in Column D. rented to other organizations, or use clude cost for any period other than	Real estate tax applicable to ed for purposes other than lor	any portion of the nursing
	(A)	<b>(B)</b>	(C)	(D)
				Tax Applicable to
	Tax Index Number	Property Description	Total Tax	Nursing Home
1.	09-03-207-014	See Attached	\$ 100,796.64	100,796.64
2.		· .	<u> </u>	\$
3.			<u> </u>	\$
4.		· .	\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			<u> </u>	\$
9.			\$	\$
10.			<u> </u>	
		TOTA	LS \$ 100,796.64	100,796.64
B.	Real Estate Tax Cost Allocatio	<u>ons</u>		
	Does any portion of the tax bill a used for nursing home services?	apply to more than one nursing hom YES X		rty which is not directly
		a schedule which shows the calcula st must be allocated to the nursing h		

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

C. Tax Bills

Page 10A

STATE OF	ILLINOIS	S			Page 11
#	0010480	Report Period Reginning	06/01/04	Ending:	05/31/05

A. Square Feet: 39,189 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories  C. Does the Operating Entity? X (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization. (pracilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XII-A. See instructions.)  D. Does the Operating Entity? X (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization. (such as, but not limited to, apartments, assisted living facilities, day care, independent living facilities, CNA training facilities, etc.)  E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day care, independent living facilities, CNA training facilities, etc.)  E. List entity name, type of business, square footage, and number of beds/units available (where applicable).  F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  If so, please complete the following:  1. Total Amount Incurred:  2. Number of Years Over Which it is Being Amortized:  3. Current Period Amortization:  A. Dates Incurred:  Nature of Costs:  (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)  XI. OWNERSHIP COSTS:  1. 2. 3. 4.  4. Land.  Use Square Feet Year Acquired Cost  1. Facility 9 (1977) (1977) (1976) (1977) (1977) (1976) (1977) (1977) (1977) (1977) (1977) (1977) (1977) (1977) (1977) (1977) (1977) (1977) (1977) (1977) (1977) (1977) (1977) (1977) (1977)	acility Name & ID Number Manorca			# 0019489 Repor	t Period Beginning:	06/01/04 Ending: 05/3
C. Does the Operating Entity?	A. BUILDING AND GENERAL INFO	RMATION:				
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XII-A. See instructions.)  D. Does the Operating Entity?	A. Square Feet: 39	B. General Construction Type:	Exterior N	Iasonry Fran	e Steel	Number of Stories 2
Does the Operating Entity? X (a) Own the Equipment				<u> </u>		
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)  List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)  List entity name, type of business, square footage, and number of beds/units available (where applicable).  7. Does this cost report reflect any organization or pre-operating costs which are being amortized?  If so, please complete the following:  1. Total Amount Incurred:  2. Number of Years Over Which it is Being Amortized:  3. Current Period Amortization:  4. Dates Incurred:  Nature of Costs:  (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)  L. OWNERSHIP COSTS:  1	(Facilities checking (a) or (b) mu	ist complete Schedule XI. Those checking (	(c) may complete Schedule	XI or Schedule XII-A. See in	structions.)	
E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)  List entity name, type of business, square footage, and number of beds/units available (where applicable).  F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  If so, please complete the following:  1. Total Amount Incurred:  2. Number of Years Over Which it is Being Amortized:  3. Current Period Amortization:  4. Dates Incurred:  Nature of Costs:  (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)  L. OWNERSHIP COSTS:  4. Land.  5. Square Feet Vear Acquired Cost 1. Facility Square Feet Vear Acquired Cost 1. 1977   \$ 195,699 1	Does the Operating Entity?	X (a) Own the Equipment	(b) Rent equipme	ent from a Related Organiza	tion.	(c) Rent equipment from Completely Unrelated Organization.
(such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)  List entity name, type of business, square footage, and number of beds/units available (where applicable).  Does this cost report reflect any organization or pre-operating costs which are being amortized?  If so, please complete the following:  1. Total Amount Incurred:  2. Number of Years Over Which it is Being Amortized:  3. Current Period Amortization:  Nature of Costs:  (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)  4. OWNERSHIP COSTS:  A. Land.  1 2 3 4  A. Land.  Use Square Feet Year Acquired Cost  1 Facility 1977 \$ 195,699 1	(Facilities checking (a) or (b) mu	ist complete Schedule XI-C. Those checkin	ng (c) may complete Schedu	le XI-C or Schedule XII-B. S	ee instructions.)	5
If so, please complete the following:  1. Total Amount Incurred:  2. Number of Years Over Which it is Being Amortized:  3. Current Period Amortization:  4. Dates Incurred:  Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)  I. OWNERSHIP COSTS:  A. Land.  Use Square Feet Year Acquired Cost  1 Facility 1976 195,699 1					training facilities, etc.	)
If so, please complete the following:  1. Total Amount Incurred:  2. Number of Years Over Which it is Being Amortized:  3. Current Period Amortization:  Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)  COWNERSHIP COSTS:  1 2 3 4  A. Land.  Use Square Feet Year Acquired Cost 1 Facility 1977 \$ 195,699 1						
If so, please complete the following:  1. Total Amount Incurred:  2. Number of Years Over Which it is Being Amortized:  3. Current Period Amortization:  Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)  OWNERSHIP COSTS:  1 2 3 4  A. Land.  Use Square Feet Year Acquired Cost 1 Facility 1977 \$ 195,699 1						
If so, please complete the following:  1. Total Amount Incurred:  2. Number of Years Over Which it is Being Amortized:  3. Current Period Amortization:  Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)  A. COWNERSHIP COSTS:  1 2 3 4  A. Land.  Use Square Feet Year Acquired Cost 1 Facility 1977 \$ 195,699 1						
If so, please complete the following:  1. Total Amount Incurred:  2. Number of Years Over Which it is Being Amortized:  3. Current Period Amortization:  Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)  A. Land.  1						
3. Current Period Amortization:  Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)  I. OWNERSHIP COSTS:  1 2 3 4  A. Land. Use Square Feet Year Acquired Cost 1 Facility 1977 \$ 195,699 1			are being amortized?		YES	X NO
Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)  I. OWNERSHIP COSTS:  1 2 3 4  A. Land.  Use Square Feet Year Acquired Cost 1 Facility 1977 \$ 195,699 1	1. Total Amount Incurred:		2.	Number of Years Over Wh	ich it is Being Amortize	ed:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)  I. OWNERSHIP COSTS:  1 2 3 4  A. Land.  Use Square Feet Year Acquired Cost 1 Facility 1977 \$ 195,699 1	3. Current Period Amortization:		4.	Dates Incurred:		
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)  I. OWNERSHIP COSTS:  1 2 3 4  A. Land.  Use Square Feet Year Acquired Cost 1 Facility 1977 \$ 195,699 1		Noture of Costs				
1 2 3 4  A. Land. Use Square Feet Year Acquired Cost  1 Facility 1977 \$ 195,699 1		- 1000000 00 00 00 00 00 00 00 00 00 00 0	etailing the total amount of	organization and pre-operat	ing costs.)	
1 2 3 4  A. Land. Use Square Feet Year Acquired Cost  1 Facility 1977 \$ 195,699 1		•			,	
A. Land.	I. OWNERSHIP COSTS:					
1 Facility 1977 \$ 195,699 1		1	2	2	1	
2 Facility addition 2004 33,809 2	A. Land.					
	A. Land.	Use		Year Acquired	Cost	1

STATE OF ILLINOIS Page 12 Facility Name & ID Number Manorcare at Westmont # 001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0019489 Report Period Beginning: 06/01/04 Ending: 05/31/05

	b. Bullai	ng Depreciation-Including Fixed Equ	uipment. (See insti	ructions.) Kour	d an numbers to near						
	1		2	3	4	5	6	7	8	9	
		FOR BHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	155			1977	\$ 1,372,073	\$ 56,883		\$ 56,883	\$	\$ 1,015,376	4
5				2004	1,903,806						5
6											6
7											7
8											8
	Impro	vement Type**									
9	<b>Current Year</b>	Depreciation				331,118		331,118		1,647,078	9
10				1985	42,165						10
11				1986	9,808						11
12				1987	118,541						12
13				1988	118,593						13
14				1989	58,768						14
15				1990	15,910						15
16				1991	58,674						16
17				1992	84,338						17
18				1993	50,656						18
19				1994	697,677						19
20				1995	184,192						20
21				1996	118,190						21
22				1997	90,456						22
23				1998	253,224						23
24				1999	3,181						24
25				2000	85,888						25
26				2001	224,426						26
		LCOVERING		2002	1,404						27
		REATMENTS		2002	907						28
	PAINT, WVC			2002	8,512						29
		ONE JACKS		2002	476						30
		VORK & FIXTURES		2002	2,699						31
		TION OF NEW INTERIOR WALL		2002	1,930						32
		/ RETAINING WALL		2002	11,871						33
	STORAGE R			2003	6,740						34
		LCOVERING		2003	7,131						35
36	CARPET	·	·	2003	1,744						36

See Page 12A, Line 70 for total

\*Total beds on this schedule must agree with page 2.
\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Westmont # 001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar.

B. Building Depre	ciation-Including Fixed Equipment. (See inst	ructions.) Round	an numbers to near	est donar.	6	7	8	0	
1		Year	-	Current Book	Life	Straight Line	o	Accumulated	
Improvement Tv	ne**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
	PT. COST & INTEREST		\$ 3,554	¢ Depreciation	III Tears	¢	Aujustinents	¢	37
38 WALLCOVERING &		2003	16.639	φ		φ	φ	φ	38
		2003	4.875						
	TON MADE & INSTALLED		, , , , , , , , , , , , , , , , , , ,						39
	LED & EXTEND WALL	2003	14,827						40
41 BIFOLD OPERATO		2003	2,446						41
42 WALLCOVERING &		2004	2,250						42
43 General Build Overh	ead & Interest	2004	117,867						43
44 Carpentry		2004	26,990						44
45 Mill Work		2004	4,207						45
46 Doors & Frames		2004	24,238						46
47 Windows		2004	10,470						47
48 Flooring		2004	1,012						48
49 Wallcovering & Corn		2004	99,668						49
50 Fire Sprinkler System	1	2004	800						50
51 Plumbing		2004	1,626						51
52 Electrical		2004	4,889						52
53 Bldg Addtn - Archite	ct, Engineering, Permits, Plan Reviews	2004	223,090						53
	Overhead Costs & Interest	2004	616,107						54
55 Bldg Addtn - Carpeti	ng	2004	21,109						55
	ering & Corner Guards	2004	25,299						56
57 Bldg Addtn - Millwor	k	2004	11,524						57
58 Bldg Addtn - Soil & C	Concrete Testing, Water & Sewer Fees	2004	108,430						58
59 Bldg Addtn - Land Pr	rep/Improvements for Construction	2004	284,371						59
60 Bldg Addtn - Paving		2004	57,718						60
61 Garage Renov Roof	, Decking, Door, Siding, Soffits	2004	9,820						61
62 Doors		2004	13,114						62
63 Repair Wall & VWC		2004	7,292						63
64									64
65									65
66									66
67									67
68									68
69									69
70 TOTAL (lines 4 thru	69)		\$ 7,248,212	\$ 388,001		\$ 388,001	\$	\$ 2,662,454	70

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

STA	TE	$\mathbf{OF}$	TT :	LI	IOV	C

Page 13 Facility Name & ID Number Mar XI. OWNERSHIP COSTS (continued) **Manorcare at Westmont** 0019489 **Report Period Beginning:** 06/01/04 05/31/05 **Ending:** 

C. Ec	uipment	Depreciation-Ex	xcluding Trans	portation. (See	instructions.)
-------	---------	-----------------	----------------	-----------------	----------------

	Category of	1	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 1,468,909	\$ 119,639	\$ 119,639	\$		\$ 1,166,469	71
72	Current Year Purchases	500,675						72
73	Fully Depreciated Assets							73
74	Retirement & Home Office Dep	or (5,100)		23,412	23,412		(3,614)	74
75	TOTALS	\$ 1,964,484	\$ 119,639	\$ 143,051	\$ 23,412		\$ 1,162,855	75

### D. Vehicle Depreciation (See instructions.)\*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

### E. Summary of Care-Related Assets

7	٠
	è

		Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,442,204	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 507,640	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 531,052	83 *
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 23,412	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,825,309	85

1

### F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

### G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

<sup>\*\*</sup> This must agree with Schedule V line 30, column 8.

						STA	TE OF ILLINOIS						Page 14
Faci	lity Name & II	) Number	Manorcare at V	Vestmont		#	0019489	Report	Period I	Beginning:	06/01/04	Ending:	05/31/05
XII.	1. Name of P 2. Does the f	nd Fixed Equi Party Holding	pment (See instruct Lease: y real estate taxes in		amount shown below on	ı line 7,	column 4?	]NO					
		1 Year Constructe	2 Number d of Beds	3 Original Lease Date	4 Rental		5 Total Years of Lease	6 Total Years Renewal Option*					
4	Original Building: Additions	Constructe	d of Beds	Lease Date	Amount \$		of Lease	Renewal Option*	3 4		dates of current		nent:
5 6 7	TOTAL				\$				5 6 7	11. Rent to be rental agr	e paid in future y	years under t	he current
	This amou	unt was calculated and the least	rtization of lease expated by dividing the	total amount to be			*			12. 13.	/2006 /2007 /2008	Annual Ro	ent
	B. Equipment	t-Excluding T	ransportation and F rental included in b vable equipment:	ixed Equipment. (S uilding rental?		: 02 C	oncentrators, Who	NO eelchairs, Gerichairs e detailing the breal		eds, Etc.		Φ	
	C. Vehicle Re	ental (See instr											
	1 Use		2 Model Year and Make	]	3 Monthly Lease Payment		4 Rental Expense for this Period			* If there	is an option to b	uy the buildi	ng,
17 18 19	N/A			\$		\$		17 18 19		please p schedul	orovide complete e.	details on at	tached
20			<u></u>					20		** This am	ount plus any a	nortization o	f lease
21	TOTAL			\$		\$		21		expense	must agree with	page 4, line	<u>34.</u>

			5	STATE OF ILLI	NOIS					Page 15
	ne & ID Number Manorcare at Westmo				#	0019489	Report Period Beginning:	06/01/04	<b>Ending:</b>	05/31/05
XIII. EXPE	NSES RELATING TO CERTIFIED NURSE AIDE	(CNA) TRAINING	PROGRAMS (See	e instructions.)	-					
A. TYI	PE OF TRAINING PROGRAM (If CNAs are traine	ed in another facilit	y program, attach a	a schedule listing	the facility	name, addre	ess and cost per CNA trained in	that facility.)		
1.	HAVE YOU TRAINED CNAs	YES 2	2. CLASSROOM	I PORTION:			3. CLINICAL PO	ORTION:	_	
	DURING THIS REPORT									
	PERIOD?	X NO	IN-HOUSE PE	ROGRAM			IN-HOUSE PR	OGRAM		
			W. OFFER E.	CVV VMVV			N. OFFICE D.	OFF TOP 1		
	Tell II I I I I I I I		IN OTHER FA	ACILITY			IN OTHER FA	CILITY		
	If "yes", please complete the remainder		COMMUNITS	COLLEGE			HOURS DED.	TAT A		
	of this schedule. If "no", provide an		COMMUNITY	COLLEGE			HOURS PER O	_NA		
	explanation as to why this training was		HOURS PER	CNIA						
	not necessary.		HOURSTER	CNA						
B. EXI	PENSES	17.7.0.C.I.T	TON OF GOGEG	(1)			C. CONTRACTUAL II	NCOME		
		ALLOCAT	ION OF COSTS	<b>(d)</b>			* 4 1 11	1.0		
		4	2	2		4	In the box belo			
		1 TE.	2 acility	3		4	facility received	i training CN	AS Irom our	ier facilities.
		Drop-outs	Completed	Contract	-	Total	· ·		7	
1 0	ommunity College Tuition	© Drop-outs	Completed	Contract	•	10141	Φ		_	
	ooks and Supplies	φ	Φ	Φ	Ψ		D. NUMBER OF CNA	TRAINED		
	lassroom Wages (a)						D. NUMBER OF CNAS	KAINED		
	linical Wages (b)						COMPLET	red		
	n-House Trainer Wages (c)						1. From this fa			
	ransportation (c)	+	+				2. From other f			
	ontractual Payments	+	+				DROP-OU			
	NA Competency Tests						1. From this fa			
	OTALS	\$	\$	\$	\$		2. From other t			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- $\left(c\right)$  For in-house training programs only. Do not include fringe benefits.

(e)

SUM OF line 9, col. 1 and 2

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

TOTAL TRAINED

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Manorcare at Westmont# 0019489Report Period Beginning:

### XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

Facility Name & ID Number

		1		2		3	4		5		6	7	8		
		Schedule V		Staff		Staff		Outsio	Outside Practitioner			Supplies			
	Service	Line & Column	Un	nits of		Cost	(other t	than	consultant)		(Actual or)	Total Units	Total Cost		
		Reference	Se	rvice			Units		Cost		Allocated)	(Column 2 + 4)	(Col. $3 + 5 + 6$ )		
1	Licensed Occupational Therapist	10a	2909	hrs	\$	88,414	4,766	\$	217,421	\$	2,007	7,675	\$ 307,842	1	
	Licensed Speech and Language														
2	Development Therapist	10a	1101	hrs		34,765	758		34,598		597	1,859	69,960	2	
3	Licensed Recreational Therapist			hrs			3		159			3	159	3	
4	Licensed Physical Therapist	10a	3193	hrs		102,646	5,111		233,184		8,839	8,304	344,669	4	
5	Physician Care			visits										5	
6	Dental Care			visits										6	
7	Work Related Program			hrs										7	
8	Habilitation			hrs										8	
				# of											
9	Pharmacy	39, 2		prescrpts							594,145		594,145	9	
	Psychological Services														
	(Evaluation and Diagnosis/														
10	Behavior Modification)			hrs										10	
11	Academic Education			hrs										11	
12	<b>Exceptional Care Program</b>													12	
13	Other (specify): X-ray & Lab	43, 3							91,846				91,846	13	
					l										
14	TOTAL				\$	225,825	10,639	\$	577,208	\$	605,588	17,842	\$ 1,408,621	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

XV. BALANCE SHEET - Unrestricted Operating Fund.
This report must be completed even if financial statements are attached. As of 05/31/05 (last day of reporting year)

	This report must be completed than	1		2 After	
		O	perating	Consolidation*	
	A. Current Assets				
1	Cash on Hand and in Banks	\$	30,798	\$	1
2	Cash-Patient Deposits				2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance 251,612 )		2,152,194		3
4	Supply Inventory (priced at 03/31/05 )		41,136		4
5	Short-Term Investments				5
6	Prepaid Insurance				6
7	Other Prepaid Expenses		77,265		7
8	Accounts Receivable (owners or related parties)				8
9	Other(specify):				9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	2,301,393	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments				12
13	Land		229,508		13
14	Buildings, at Historical Cost		7,248,212		14
15	Leasehold Improvements, at Historical Cost				15
16	Equipment, at Historical Cost		1,964,484		16
17	Accumulated Depreciation (book methods)		(3,825,309)		17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):				22
23	Other(specify): Construction In Progress		15,300		23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	5,632,195	\$	24
	TOTAL ACCETS				
25	TOTAL ASSETS	Φ.	5 022 500	ф	25
25	(sum of lines 10 and 24)	\$	7,933,588	\$	25

		1	perating	2 After Consolidation*	
	C. Current Liabilities				
26	Accounts Payable	\$	131,973	\$	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits				28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable		396,057		30
	Accrued Taxes Payable				
31	(excluding real estate taxes)				31
32	Accrued Real Estate Taxes(Sch.IX-B)		93,237		32
33	Accrued Interest Payable				33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36	Accrued Payables		94,661		36
37	-		•		37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	715,928	\$	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable				39
40	Mortgage Payable				40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43					43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$		\$	45
	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	715,928	\$	46
			•		
47	TOTAL EQUITY(page 18, line 24)	\$	7,217,660	\$	47
	TOTAL LIABILITIES AND EQUITY				
48	(sum of lines 46 and 47)	\$	7,933,588	\$	48

<sup>\*(</sup>See instructions.)

**Ending:** 

T CI	HANGES IN EQUITY		1	
			Total	
1	Balance at Beginning of Year, as Previously Reported	\$	6,809,522	1
2	Restatements (describe):	<u>'</u>		2
3				3
4				4
5				5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6,809,522	6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		2,565,813	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants			11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	(	)	13
14	Donated Property, Plant, and Equipment			14
15	Other (describe)			15
16	Other (describe)			16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	2,565,813	17
	B. Transfers (Itemize):			
18	Changes in Interdivison		(2,157,675)	18
19				19
20				20
21				21
22				22
23	TOTAL Transfers (sum of lines 18-22)	\$	(2,157,675)	23

24 BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)

7,217,660

24 \*

<sup>\*</sup> This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue		Amount	
	A. Inpatient Care			
1	Gross Revenue All Levels of Care	<b>\$</b>	10,602,989	1
2	Discounts and Allowances for all Levels		(2,017,147)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$	8,585,842	3
	B. Ancillary Revenue			
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy		3,553,116	6
7	Oxygen		8,242	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	3,561,358	8
	C. Other Operating Revenue			
9	Payments for Education			9
10	Other Government Grants			10
11	CNA Training Reimbursements			11
12	Gift and Coffee Shop		1,767	12
13	Barber and Beauty Care		22,656	13
14	Non-Patient Meals		429	14
15	Telephone, Television and Radio		9,297	15
16	Rental of Facility Space			16
17	Sale of Drugs		568,049	17
18	Sale of Supplies to Non-Patients			18
19	Laboratory		69,272	19
20	Radiology and X-Ray		38,705	20
21	Other Medical Services		75	21
22	Laundry		6,471	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	716,721	23
	D. Non-Operating Revenue			
24	Contributions			24
25	Interest and Other Investment Income***			25
26		\$		26
	E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)			27
28	Misc. Income		1,736	28
28a	Late Charges		631	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	2,367	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$	12,866,288	30

		2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,234,816	31
32	Health Care	5,048,264	32
33	General Administration	2,340,928	33
	B. Capital Expense		
34	Ownership	718,103	34
	C. Ancillary Expense		
35	Special Cost Centers	873,500	35
36	Provider Participation Fee	84,864	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,300,475	40
41	Income before Income Taxes (line 30 minus line 40)**	2,565,813	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,565,813	43

*	This must agree with page 4, line 45, column 4.

*	Does this agree with	taxable income (loss) per Federal Income
	Tax Return?	If not, please attach a reconciliation.

See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

<sup>\*\*\*\*</sup>Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Manorcare at Westmont

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	(1 ms schedule must cover the	1	2**	3	4	
		# of Hrs.	# of Hrs.	Reporting Period	Average	
		Actually	Paid and	Total Salaries,	Hourly	
		Worked	Accrued	Wages	Wage	
1	Director of Nursing	2,368	2,558	\$ 94,278	\$ 36.86	1
2	Assistant Director of Nursing	5,254	5,676	163,754	28.85	2
3	Registered Nurses	35,214	38,048	1,035,700	27.22	3
4	Licensed Practical Nurses	39,965	43,181	939,714	21.76	4
5	CNAs & Orderlies	100,923	109,052	1,238,758	11.36	5
6	CNA Trainees					6
7	Licensed Therapist	7,184	7,795	245,039	31.44	7
	Rehab/Therapy Aides	12,636	13,711	260,233	18.98	8
9	Activity Director	8,018	8,693	102,480	11.79	9
10	Activity Assistants					10
11	Social Service Workers	3,699	4,026	60,208	14.95	11
	Dietician					12
	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,044	31,502	349,286	11.09	15
	Dishwashers					16
17	Maintenance Workers	2,133	2,311	43,729	18.92	17
	Housekeepers	16,649	18,051	182,525	10.11	18
	Laundry	6,418	6,959	58,345	8.38	19
	Administrator	2,080	2,080	78,433	37.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,808	24,957	434,233	17.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
	Habilitation Aides (DD Homes)					30
	Medical Records	2,350	2,550	31,780	12.46	31
32	Other Health Care(specify)					32
33	Other(specify) Hospitality	1,216	1,320	15,371	11.64	33
34	TOTAL (lines 1 - 33)	297,959	322,470	\$ 5,333,866 *	\$ 16.54	34

<sup>\*</sup> This total must agree with page 4, column 1, line 45.

## B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	33,030	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,595	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 38,625		49

### C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53
	•				

<sup>\*\*</sup> See instructions.

STATE OF ILLINOIS	
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	anorcare at West	mont			# 0019489	R	eport	Period Begin	ıning:	06/01/04	Ending	:	05/31/05
XIX. SUPPORT SCHEDULES													
A. Administrative Salaries		Ownership	)		D. Employee Benefits and Payroll Taxes	es			F. Dues, F	ees, Subscriptions and	Promotic	ons	
Name	Function	%		Amount	Description		A	mount		Description			Amount
Jennifer Miller	Administator	0	\$_	78,433	Workers' Compensation Insurance		\$	58,732	IDPH Lic			\$	5,589
			_		<b>Unemployment Compensation Insurance</b>	ce		80,666	Advertisin	ng: Employee Recruitr	nent		38,340
			_		FICA Taxes			379,571	Health Ca	re Worker Backgrour	d Check		
<u> </u>					Employee Health Insurance			257,776	(Indicate	of checks performed	276		5,226
<u>.                                      </u>		· · · · · · · · · · · · · · · · · · ·			Employee Meals				Dues & Su	bscriptions			370
<u> </u>					Illinois Municipal Retirement Fund (IM	/IRF)*			Associatio	n Dues			8,241
<u> </u>					Employee Appreiation			16,617	Advertisin	g			49,840
TOTAL (agree to Schedule V, line 1	17, col. 1)				401K			34,580	Public Rel	ations			226
(List each licensed administrator se	parately.)		\$	78,433	Other Employee Benefits			(246)			_	_	
B. Administrative - Other					Tuition Program			7,484	Less Non-	allowable Association l	Dues		(2,663
					SMSP Match					blic Relations Expense		_	(226
Description				Amount	Employee Uniforms			3,868		n-allowable advertising		_	(49,840
Management Fees			\$	459,726	Home Office Allocation			53,826	Yel	low page advertising		( -	
		_	-									` _	
			_		TOTAL (agree to Schedule V,		\$	892,874		TOTAL (agree to So	eh. V,	\$	55,103
			_		line 22, col.8)					line 20, col.	8)	_	
TOTAL (agree to Schedule V, line 1	17, col. 3)		\$	459,726	E. Schedule of Non-Cash Compensation	n Paid			G. Schedu	le of Travel and Semi			
(Attach a copy of any management	service agreemen	t)	=		to Owners or Employees								
C. Professional Services		,			1					Description			Amount
Vendor/Pavee	Type			Amount	<b>Description</b> Lin	ne#	A	mount					
Foote, Meyers, Mielke, Flowers, LL			\$	17,250	2 con prior		\$		Out-of-St	ate Travel		\$	
Manhard Consulting	Legal Fees		Ψ_	249			Ψ		out or bu	114101		Ψ_	
William Consuming	Legar rees		-				_					_	
Physicians Credit Bureau	Fees for collecti	ons	-	242					In-State T	ravel		_	3,328
I njoichais Cicuit Burcau	1 ces for conecti	OII.	-							avel expense to the Ho	me	_	3,320
	<del></del>		-							oledo, OH for regiona		_	
	<del></del>		-						Office III 1	orcuo, OTI for regiona	i meetings	' –	
			-						Seminar I	Evnence		_	
		-	-						Seminal I	алренос		_	
Legal fees were adjusted off on Scho	edule VI Page 5	Line 22	-									_	
Therefore, no legal invoices are atta			-									_	
Therefore, no legal invoices are atta	· ·		-						Entartain	ment Expense		. –	
TOTAL (agree to Schedule V, line 1	19 column 3)		-		TOTAL		\$		Enter talli	(agree to Sch. V	v	' _	
(If total legal fees exceed \$2500 atta	,	ne )	Ф	17,741	TOTAL		Ψ		TOTAL	line 24, col. 8)	/	¢	3,328
(II total legal lees exceed \$2500 atta	ch copy of invoice	:5.)	<b>.</b>	17,741	* A 44-al-a				**C	, ,		Ψ	3,340

<sup>\*</sup> Attach copy of IMRF notifications

Page 21

<sup>\*\*</sup>See instructions.

STATE OF ILLINOIS							Page 22
Facility Name & ID Number	Manorcare at Westmont	# 0	019489	Report Period Reginning	06/01/04	Ending:	05/31/05

 $XIX-H.\ SUPPORT\ SCHEDULE\ -\ DEFERRED\ MAINTENANCE\ COSTS\ (which have been included\ in\ Sch.\ V,\ line\ 6,\ col.\ 3).$ 

	(See instructions.)				`								
	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year						Amount of	Expense Amor	tized Per Year			
	Improvement	Improvement	Total Cost	Useful									
	Type	Was Made		Life	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

			OF ILLINOIS				Page 23
	y Name & ID Number Manorcare at Westmont	#	0019489	Report Period Beginning:	06/01/04	Ending:	05/31/05
	ENERAL INFORMATION:	(4.0)					
(1)	Are nursing employees (RN,LPN,NA) represented by a union?	(13)	the Department, in	supplies and services which are of the addition to the daily rate, been properties.	erly classified	be billed to	
(2)	Are there any dues to nursing home associations included on the cost report?  Yes  If YES, give association name and amount. IHCA \$8241		in the Ancillary Se	ction of Schedule V? Yes			
(3)	Did the nursing home make political contributions or payments to a political action organization?  Yes  If YES, have these costs been properly adjusted out of the cost report?  Yes \$2663	(14)	the patient census is a portion of the l	building used for any function other listed on page 2, Section B? No building used for rental, a pharmacy explains how all related costs were a	, day care, etc.)	For exampl  If YES, attac	le,
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?  No If YES, what is the capacity?		Indicate the cost of on Schedule V. related costs?		assified to employ meal income the amount.	been offset ag	ainst
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?  Yes  5-10 years	(16)	Travel and Transpo	ortation ncluded for out-of-state travel?	No		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 62,890 Line 10		If YES, attach a	complete explanation.  eparate contract with the Departmen	nt to provide me		
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.		program during c. What percent of	this reporting period. \$ all travel expense relates to transpose age logs been maintained? N/A			
(8)	Are you presently operating under a sale and leaseback arrangement? No  If YES, give effective date of lease.		e. Are all vehicles times when not	stored at the nursing home during the in use? N/A	C		
(9)	Are you presently operating under a sublease agreement? YES X NO	)	out of the cost re	commuting or other personal use of eport? N/A ity transport residents to and fr			NT.
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over.	/,	Indicate the a	mount of income earned from p n during this reporting period.			No
		(17)	Has an audit been j Firm Name:	performed by an independent certific	ed public accou		No tions for the
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 84,864  This amount is to be recorded on line 42 of Schedule V.		cost report require been attached?	that a copy of this audit be included  If no, please explain.	with the cost r	report. Has the	is copy
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?  No If YES, attach an explanation of the allocation.	(18)	Have all costs which out of Schedule V	ch do not relate to the provision of log Yes	ong term care b	een adjusted o	out
		(19)	performed been att	re in excess of \$2500, have legal invached to this cost report?  No d a summary of services for all arch		•	ices